9STATE OF MARYLAND

DHMH

Maryland Department of Health and Mental Hygiene
201 W. Preston Street • Baltimore, Maryland 21201
Martin O'Malley, Governor – Anthony G. Brown, Lt. Governor – Joshua M. Sharfstein, M.D., Secretary

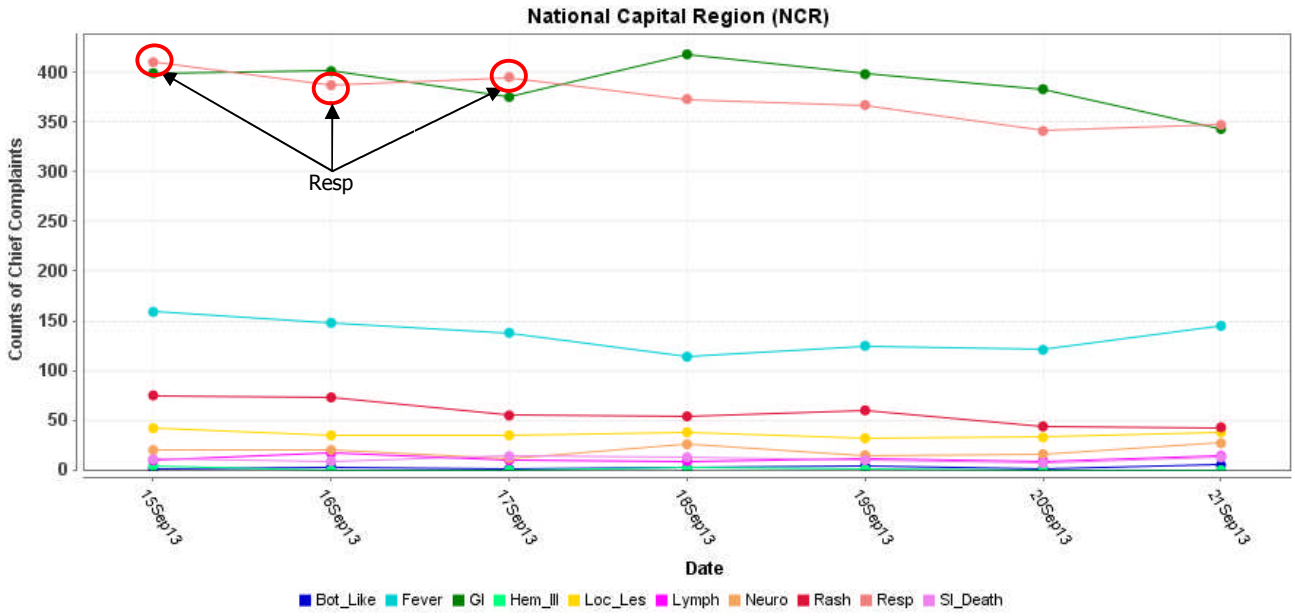
September 27, 2013

Public Health & Emergency Preparedness Bulletin: # 2013:38
Reporting for the week ending 09/21/13 (MMWR Week #38)

CURRENT HOMELAND SECURITY THREAT LEVELS

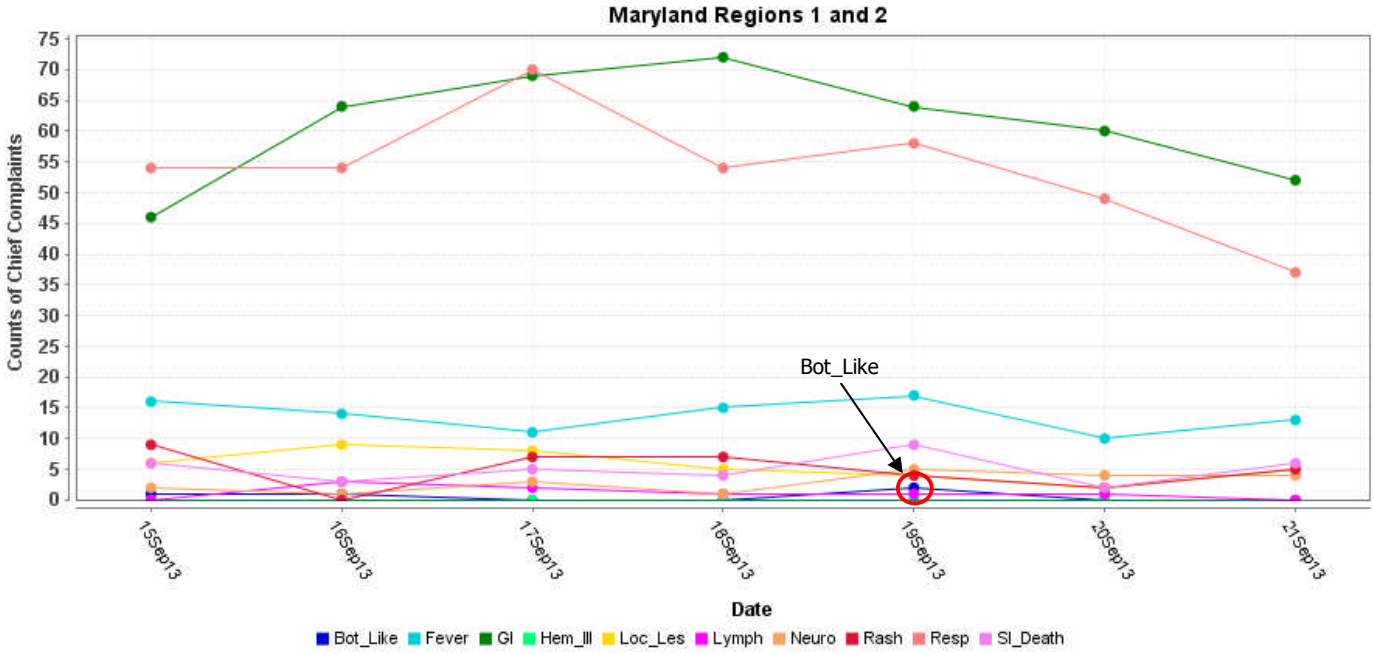
National: **No Active Alerts**
Maryland: **Level Four (MEMA status)**

SYNDROMIC SURVEILLANCE REPORTS
ESSENCE (Electronic Surveillance System for the Early Notification of Community-based Epidemics):
Graphical representation is provided for all syndromes, excluding the "Other" category, all age groups, and red alerts are circled. Red alerts are generated when observed count for a syndrome exceeds the 99% confidence interval. Note: ESSENCE – ANCR uses syndrome categories consistent with CDC definitions.
Overall, no suspicious patterns of illness were identified. Track backs to the health care facilities yielded no suspicious patterns of illness.

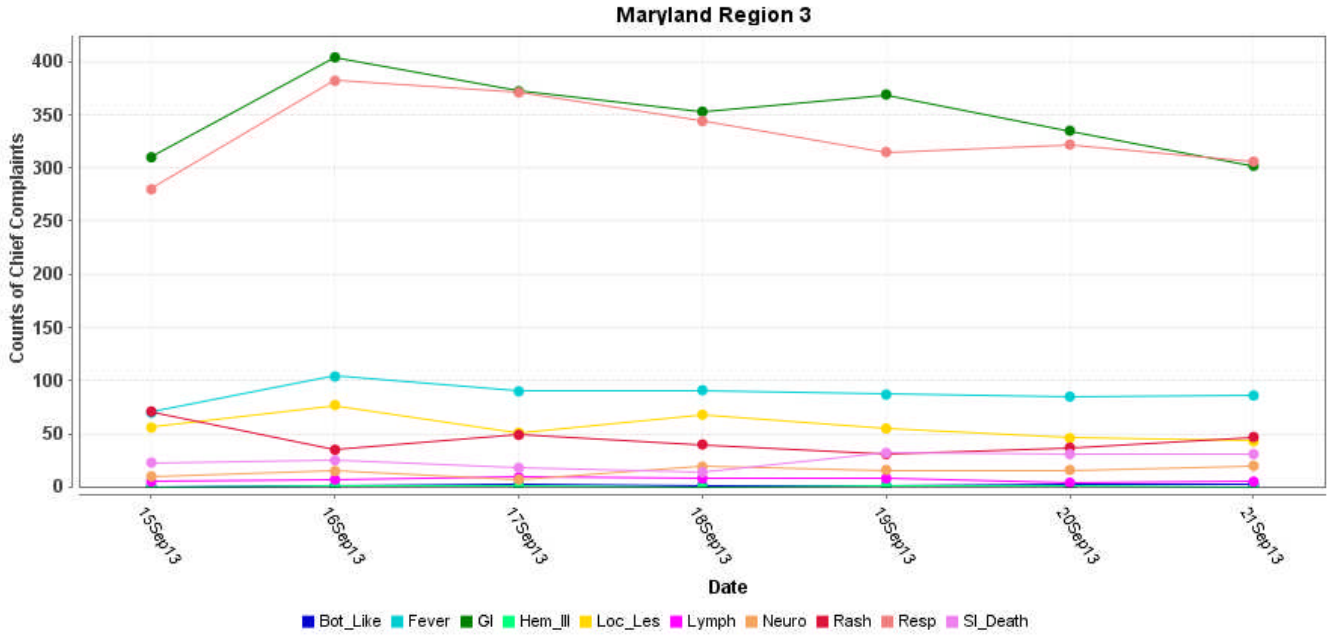


*Includes EDs in all jurisdictions in the NCR (MD, VA, and DC) reporting to ESSENCE

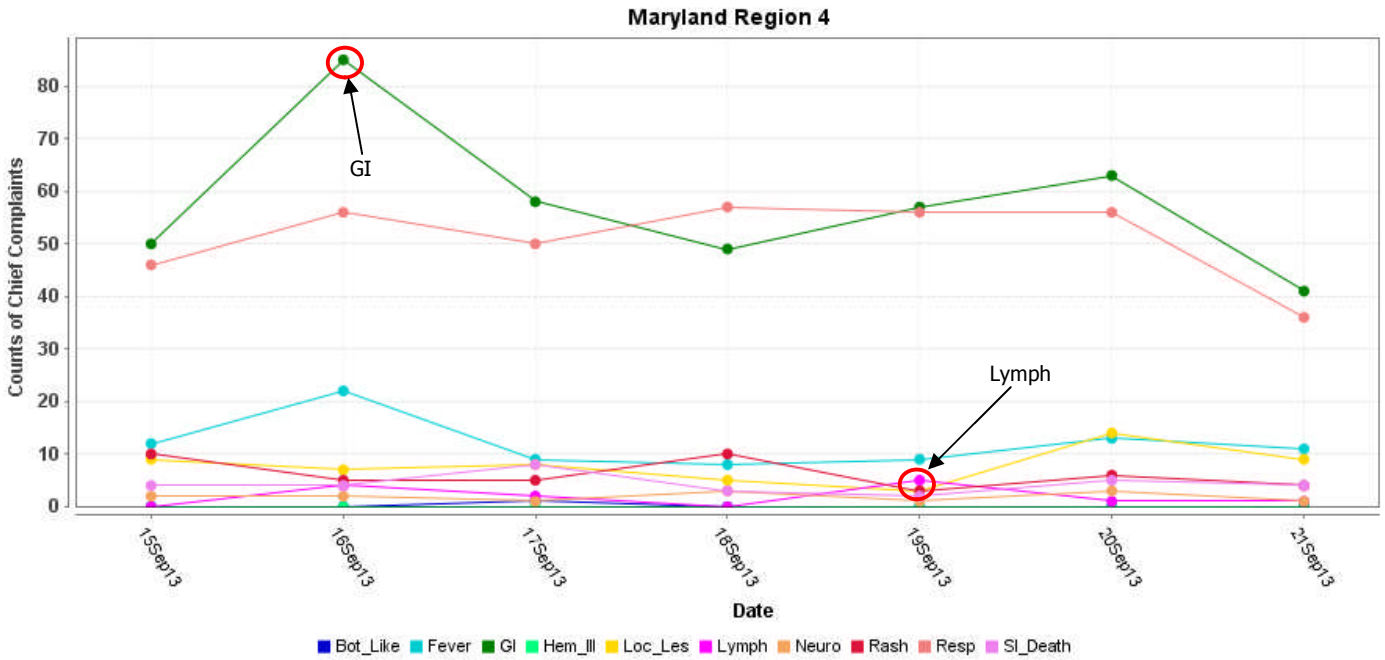
MARYLAND ESSENCE:



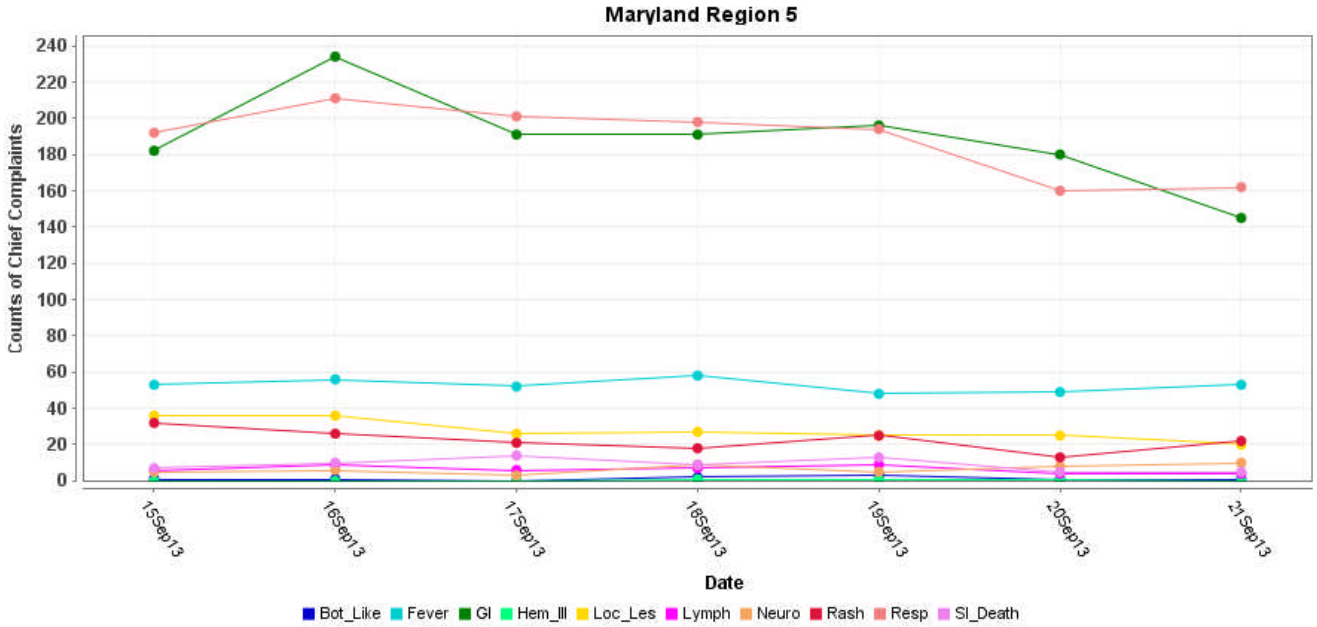
* Region 1 and 2 includes EDs in Allegany, Frederick, Garrett, and Washington counties reporting to ESSENCE



* Region 3 includes EDs in Anne Arundel, Baltimore City, Baltimore, Carroll, Harford, and Howard counties reporting to ESSENCE



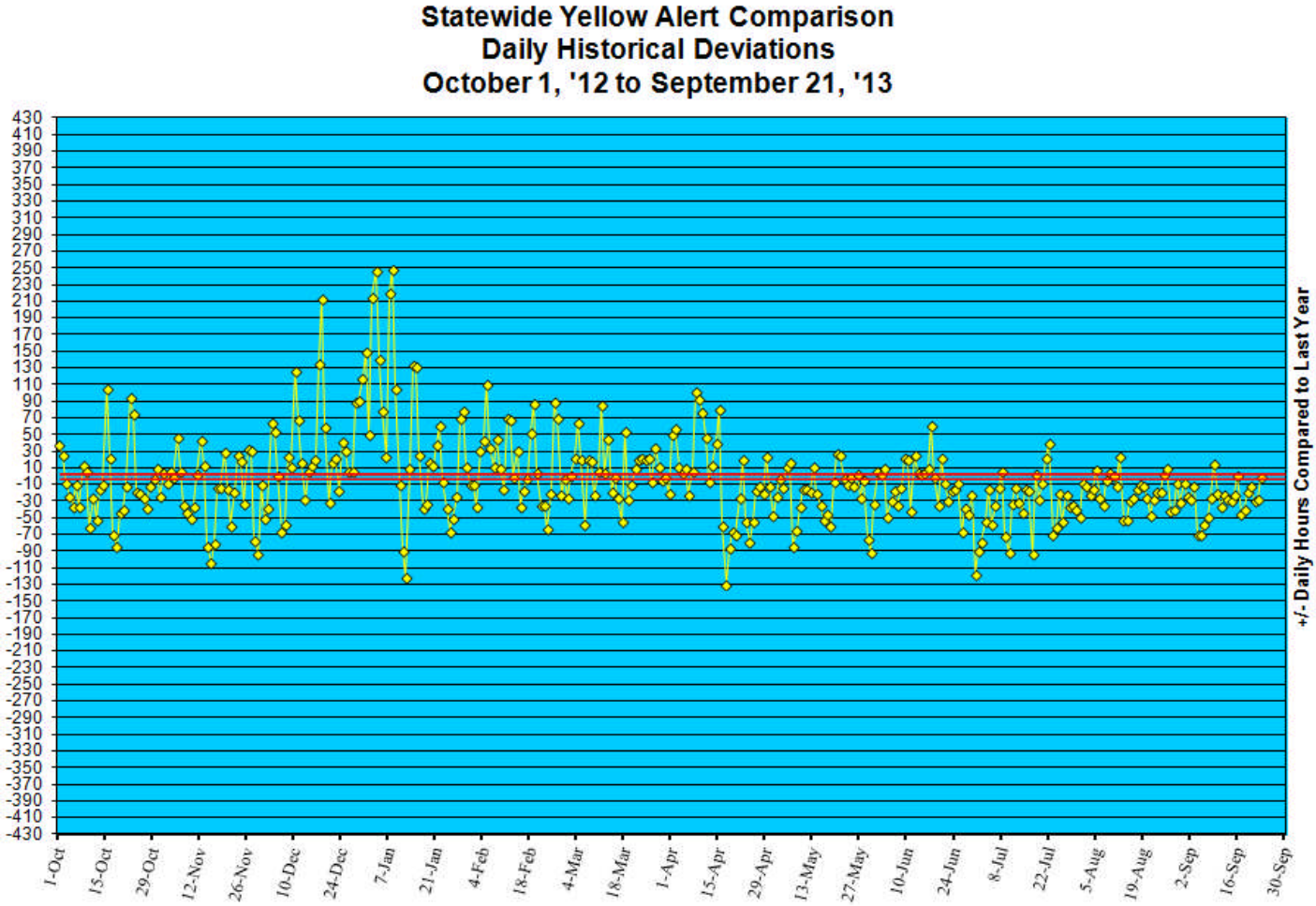
* Region 4 includes EDs in Cecil, Dorchester, Kent, Somerset, Talbot, Wicomico, and Worcester counties reporting to ESSENCE



* Region 5 includes EDs in Calvert, Charles, Montgomery, Prince George's, and St. Mary's counties reporting to ESSENCE

REVIEW OF EMERGENCY DEPARTMENT UTILIZATION

YELLOW ALERT TIMES (ED DIVERSION): The reporting period begins 10/01/11.



REVIEW OF MORTALITY REPORTS

Office of the Chief Medical Examiner: OCME reports no suspicious deaths related to an emerging public health threat for the week.

MARYLAND TOXIDROMIC SURVEILLANCE

Poison Control Surveillance Monthly Update: Investigations of the outliers and alerts observed by the Maryland Poison Center and National Capital Poison Center in August 2013 did not identify any cases of possible public health threats.

REVIEW OF MARYLAND DISEASE SURVEILLANCE FINDINGS

COMMUNICABLE DISEASE SURVEILLANCE CASE REPORTS (confirmed, probable and suspect):

Meningitis:	**Aseptic**	**Meningococcal**
New cases (September 15 - September 21, 2013):	5	0
Prior week (September 8 - September 14, 2013):	13	0
Week#38, 2012 (September 17 – September 23, 2012):	17	0

2 outbreaks were reported to DHMH during MMWR Week 38 (September 15 – September 21, 2013)

1 Gastroenteritis Outbreak
1 outbreak of GASTROENTERITIS associated with a Daycare Center

1 Rash Illness Outbreak
1 outbreak of SCABIES in a Nursing Home

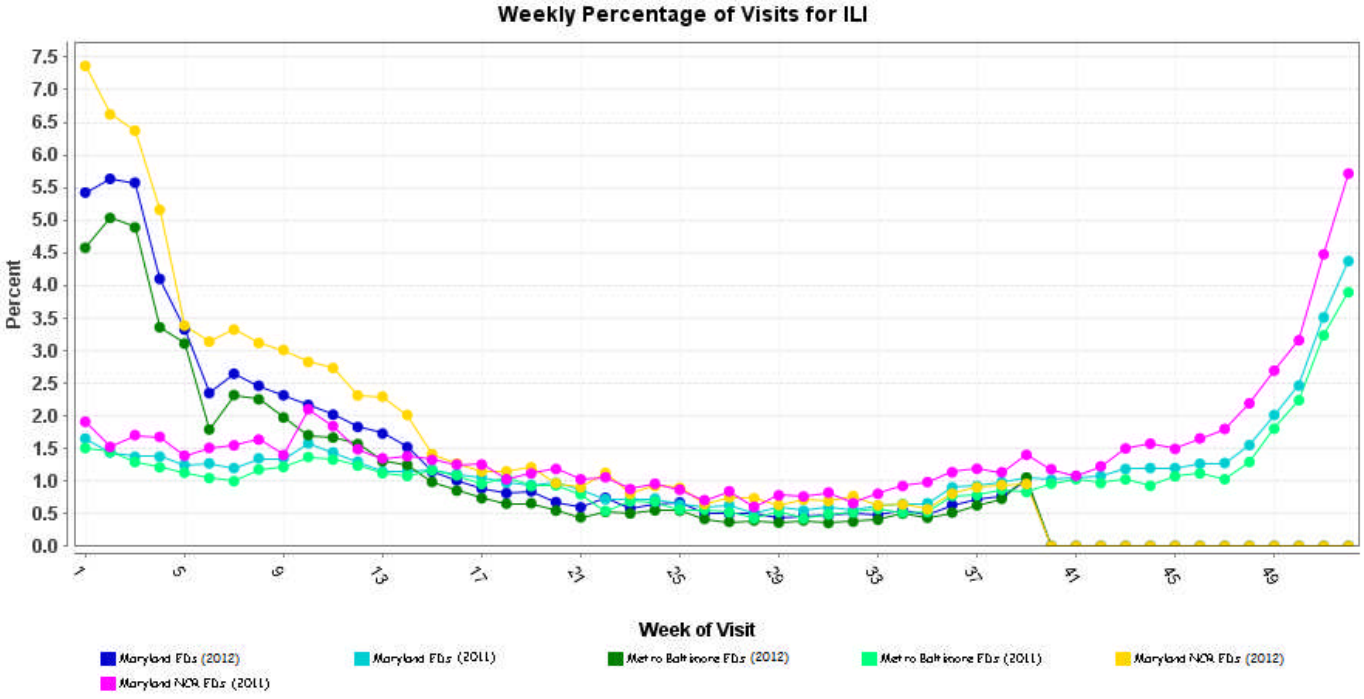
MARYLAND SEASONAL FLU STATUS

Seasonal Influenza reporting occurs October through May.

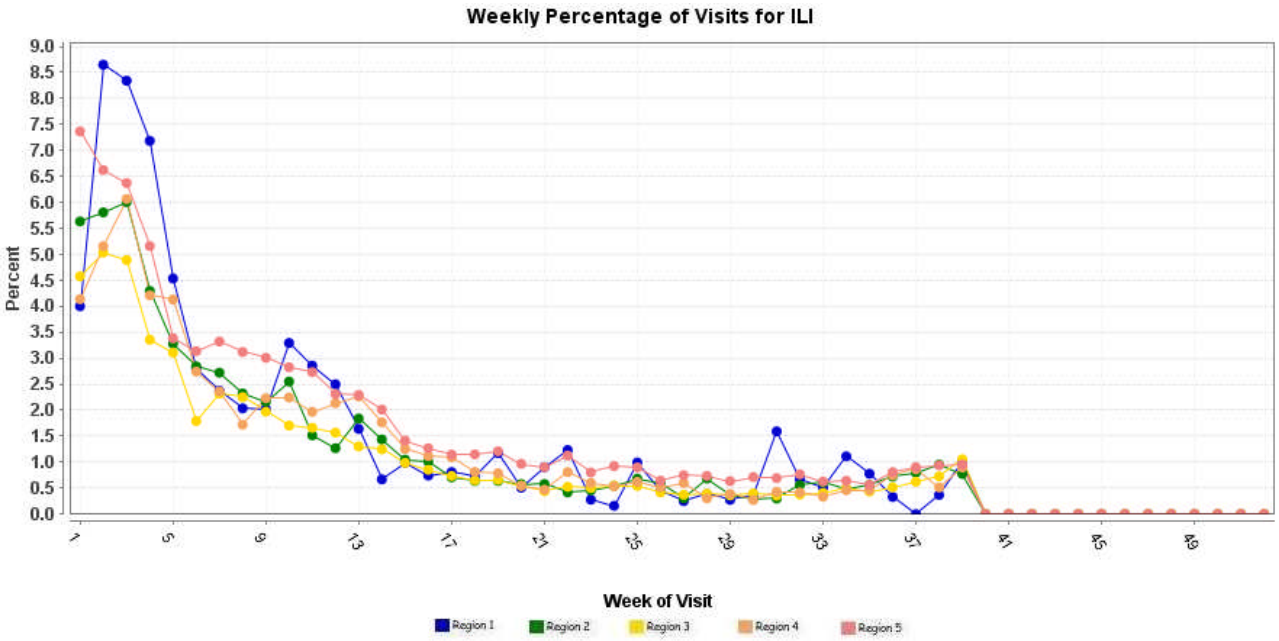
SYNDROMIC SURVEILLANCE FOR INFLUENZA-LIKE ILLNESS

Graphs show the percentage of total weekly Emergency Department patient chief complaints that have one or more ICD9 codes representing provider diagnoses of influenza-like illness. These graphs do not represent confirmed influenza.

Graphs show proportion of total weekly cases seen in a particular syndrome/subsyndrome over the total number of cases seen. Weeks run Sunday through Saturday and the last week shown may be artificially high or low depending on how much data is available for the week.



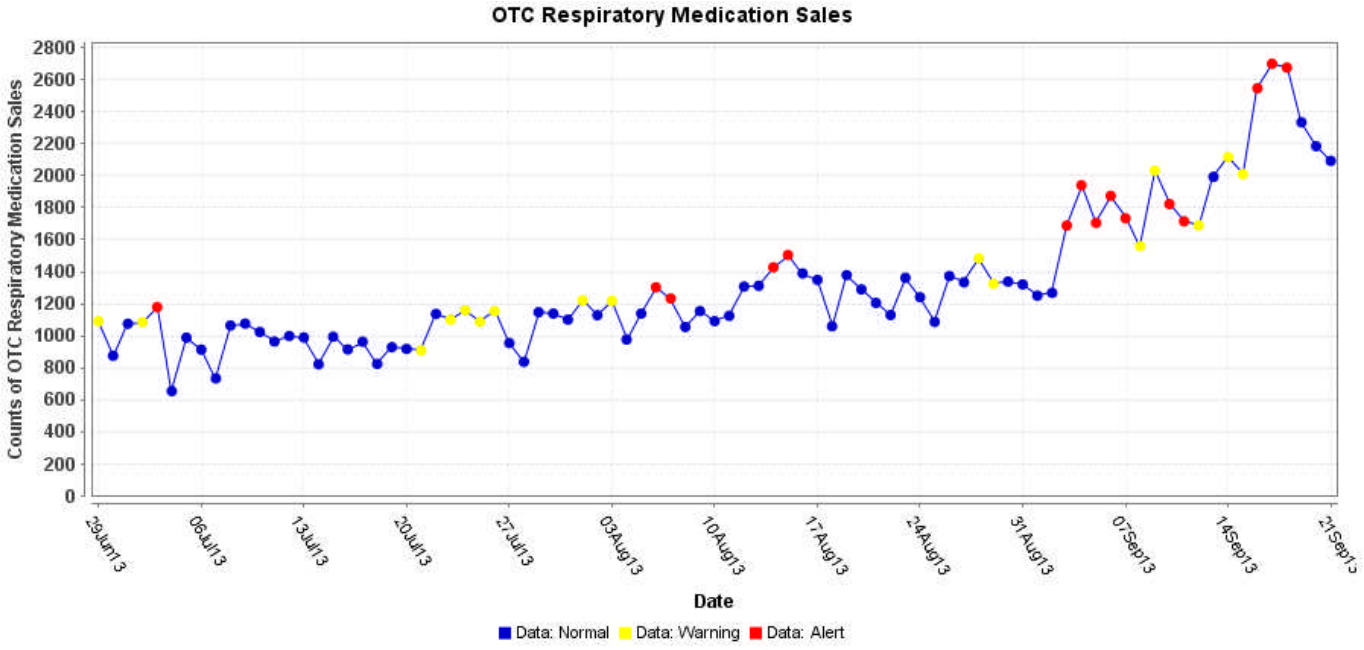
* Includes 2012 and 2013 Maryland ED visits for ILI in Metro Baltimore (Region 3), Maryland NCR (Region 5), and Maryland Total



*Includes 2013 Maryland ED visits for ILI in Region 1, 2, 3, 4, and 5

OVER-THE-COUNTER (OTC) SALES FOR RESPIRATORY MEDICATIONS:

Graph shows the daily number of over-the-counter respiratory medication sales in Maryland at a large pharmacy chain.



PANDEMIC INFLUENZA UPDATE / AVIAN INFLUENZA-RELATED REPORTS

WHO update: The current WHO phase of pandemic alert for avian influenza is ALERT. Currently, the avian influenza H5N1 virus continues to circulate in poultry in some countries, especially in Asia and northeast Africa. This virus continues to cause sporadic human infections with some instances of limited human-to-human transmission among very close contacts. There has been no sustained human-to-human or community-level transmission identified thus far.

Influenza A (H7N9) is one of a subgroup of influenza viruses that normally circulate among birds. Until recently, this virus had not been seen in people. However, human infections have now been detected. As yet, there is limited information about the scope of the disease the virus causes and about the source of exposure. The disease is of concern because most patients have been severely ill. There is no indication thus far that it can be transmitted between people, but both animal-to-human and human-to-human routes of transmission are being actively investigated.

Alert phase: This is the phase when influenza caused by a new subtype has been identified in humans. Increased vigilance and careful risk assessment, at local, national and global levels, are characteristic of this phase. If the risk assessments indicate that the new virus is not developing into a pandemic strain, a de-escalation of activities towards those in the interpandemic phase may occur. As of August 29, 2013, the WHO-confirmed global total of human cases of H5N1 avian influenza virus infection stands at 637, of which 378 have been fatal. Thus, the case fatality rate for human H5N1 is approximately 59%.

AVIAN INFLUENZA, HUMAN, H7N9 (CHINA): 19 September 2013, Deadly H7N9 avian flu viruses infected people for the 1st time earlier this year [2013] in China, but little is known about how they evolved to become harmful to humans. In a study published by Cell Press on [19 Sep 2013] in Cell Host and Microbe, an in-depth evolutionary analysis of whole-genome sequences of different types of avian flu viruses has revealed that new H7N9 viruses emerged from distinct H9N2 viruses in a 2-step process, 1st occurring in wild birds and then continuing in domestic birds." A deep understanding of how the novel H7N9 viruses were generated is of critical importance for formulating proper measures for surveillance and control of these viruses and other potential emerging influenza viruses," says senior study author Taijiao Jiang of the Chinese Academy of Sciences. First detected in people in late March [2013], H7N9 viruses have resulted in more than 130 human infections and at least 44 deaths. Most of these infections occurred after exposure to infected poultry or contaminated environments rather than person-to-person contact, but these viruses could evolve to become more readily transmissible among humans. This possible threat highlights the importance of understanding the evolutionary history of H7N9 viruses for developing appropriate strategies to monitor and control outbreaks To address this problem, Jiang teamed up with Daxin Peng of Yangzhou University and their collaborators to analyze whole-genome sequences of avian flu viruses from humans, poultry, and wild birds from China. They discovered that H7N9 viruses are genetically diverse, suggesting that complex genetic events were involved in their evolution. Their analysis revealed that the new H7N9 viruses emerged through a 2-step process involving the exchange of genetic material between distinct viruses. In the 1st step, which took place in wild birds, genetic material from H9N2 viruses and unspecified H7 and N9 viruses was mixed to create precursor H7N9 viruses. The 2nd step, which occurred in domestic birds in eastern China early last year [2012], involved the exchange of genetic material between the precursor H7N9 viruses and other H9N2 viruses to create new, genetically diverse H7N9 viruses. "Our work not only re-enforces the important role of wild birds in the emergence of novel influenza viruses but also highlights the necessity of integrating data from infections in humans, poultry, and wild birds for effective influenza surveillance," Jiang says.

NATIONAL DISEASE REPORTS*

SALMONELLOSIS (NORTH CAROLINA): 20 September 2013, More than 70 people have now reported illnesses linked to a recent local church barbecue fundraiser, according to health officials. But Cleveland County [North Carolina] Health Department officials say they believe the illness outbreak, suspected to be salmonellosis, is not continuing to spread. An investigation of the illnesses continues, according to the health department, which reports the people who got sick attended the Sandy Plains Baptist Church barbecue fundraiser on 7 Sep 2013. The health department 1st announced the illness outbreak Tuesday, 17 Sep 2013, with 9 reported sick. That number tripled to 28 the next day and increased to 54 the day after that. As of Friday, 20 Sep 2013, 71 people had reported getting sick after visiting the barbecue. Among those, 37 people are Rutherford County residents and 34 are Cleveland County residents. 13 people have been hospitalized, with 9 of those in Cleveland County, according to a news release from the health department. Health officials say the most recent date someone has reported 1st getting sick was 14 Sep 2013. (Food Safety Threats are listed in Category B on the CDC List of Critical Biological Agents) *Non-suspect case

FOODBORNE ILLNESS (USA): 17 September 2013. September 2013's voluntary recall of the popular yogurt product Chobani has resulted in more than 200 complaints from sickened customers, according to a new report from the FDA. FDA spokesperson Shelly Burgess told OregonLive.com Mon 16 Sep 2013, that the administration has received 223 complaints following the product recall. The number rose sharply from the previous 118 complaints reported by the FDA on 12 Sep 2013. But despite the hundreds of complaints of nausea, stomach cramps, diarrhea, and headaches, Burgess claims it is still not known whether the yogurt was the cause of the illnesses. "We're looking into it," she said. "This is an open investigation." (Food Safety Threats are listed in Category B on the CDC List of Critical Biological Agents) *Non-suspect case

VIBRIO PARAHAEMOLYTICUS (USA): 17 September 2013, A mystery of sorts threatens to stunt Massachusetts' small but growing oyster industry after illnesses linked to bacterial contamination forced the state to shut down beds for the first time ever. The culprit is the *Vibrio parahaemolyticus* bacterium, which has occurred in state waters since the 1960s. Theories abound about the recent increase in illnesses linked to Massachusetts -- but those are only theories. "Honestly, I'm confused by the whole thing," said Don Merry, an oyster grower from Duxbury [Massachusetts], where oyster beds have been closed. Average monthly daytime water temperatures in the region rarely approach the 81 [deg F/27.2 deg C] believed to be the threshold that triggers dangerous *Vibrio* growth. Rising average water temperatures locally, while not reaching that threshold, could be causing environmental changes that cause strains of *Vibrio* to thrive, said Suzanne Condon, associate commissioner of the Department of Health. In addition, virulent *Vibrio* strains that aren't as temperature-sensitive may have been carried from overseas in ships' ballast water in the past decade, said the state's chief shellfish biologist, Michael Hickey. Meanwhile, it has been only 6 years since states were required to federally report *Vibrio* illnesses. So testing for it is relatively slow and underdeveloped and can't yet predict, for instance, if outbreaks are coming, Hickey said. The bacterium causes gastrointestinal problems, including vomiting and cramping, but the illness is generally severe only in people with weakened immune systems. The CDC estimates the USA has about 4500 cases of *Vibrio* infection annually. Since May 2013, Massachusetts has had 50 laboratory-confirmed cases of vibriosis, compared with 27 during the same period in 2012. Other states have also seen increases in *Vibrio* -related illnesses. In August 2013, Connecticut closed oyster beds and issued a voluntary oyster recall after its 1st *Vibrio* outbreak, which sickened at least 14 people. Also in August 2013, officials in Washington's King County, where Seattle is located, warned oyster fans that *Vibrio* had sickened twice as many people as normal. Cape Cod [Massachusetts] oyster farme John Lowell said the

trouble hits everyone working to build his state's industry, though his East Dennis farm is nowhere near the closed beds. "You either hang separately or you hang together, so it affects all of us," he said. Massachusetts has about 260 oyster growers who harvested roughly USD 12 million worth of oysters in 2012. That total is dwarfed by Louisiana -- the highest-revenue oyster state, at USD 42 million -- but it's in the top 5 nationally, according to federal statistics. Hickey said a boom in aquaculture operations fueled a 67 percent increase in the value of the Massachusetts oyster catch between 2010 and 2012. Massachusetts' 1st closures were announced 30 Aug 2013 for oyster beds along the shore south of Boston, after illnesses caused by *Vibrio* were linked to an oyster-growing area in Duxbury. The 2nd closure, announced Mon 9 Sep 2013, shut down oyster beds in Katama Bay in Edgartown, on Martha's Vineyard. Combined, this year's [2013] closures affect about 14 percent of Massachusetts growers, Hickey said. (Food Safety Threats are listed in Category B on the CDC List of Critical Biological Agents) *Non-suspect case

INTERNATIONAL DISEASE REPORTS*

E. COLI EHEC (CANADA): 21 September 2013, The Public Health Agency of Canada, along with its health and food safety partners, is investigating 14 cases of *E. coli O157:H7* illness; 4 in British Columbia, 8 in Alberta, 1 in Saskatchewan and 1 in Quebec. These individuals became ill between mid-July 2013 and early September 2013. Certain contaminated cheese products manufactured by Gort's Gouda Cheese Farm in Salmon Arm, British Columbia, have been identified as the source of the illnesses. The Canadian Food Inspection Agency has recalled these products from the marketplace. There is currently no indication of widespread risk to Canadians. However, *E. coli O157:H7* can pose a serious public health risk. Additional cases of illness may be identified and linked to this outbreak in the future. Do not eat any of the recalled product. Check your refrigerator and if you have any of the recalled product in your home, return it to the point of purchase or throw it out. One of the cases in British Columbia has died as a result of *E. coli O157:H7*infection. All other cases have recovered or are recovering. *E. coli O157:H7* food-borne illnesses are not unexpected in Canada and no unusual increases in the number of these illnesses have been detected nationally. The Public Health Agency of Canada's National Enteric Surveillance Program has shown that *E. coli* cases in Canada have been declining in recent years. (Food Safety Threats are listed in Category B on the CDC List of Critical Biological Agents) *Non-suspect case

TULAREMIA (RUSSIA): 19 September 2013, According to the Department of healthcare of Khanty-Mansiysky Autonomous Region, 900 inhabitants have contracted tularemia. Among them, 858 people are residents of Khanty-Mansiysk; 33 live in Khanty-Mansiysk district; the remaining cases were recorded in Nizhnevartovsk. It is established that several of the patients in Nizhnevartovsk are employees of the oil industry and contracted tularemia in the field. In Khanty-Mansiysk and Khanty-Mansiysk district, work on measures against rodents and mosquitoes, which are the sources and carriers of disease, is continuing. According to the Department of Rospotrebnadzor [The Federal Service for Protection of Consumers' Rights and Well-Being] in the Khanty-Mansi Autonomous Okrug, the 1st cases were reported on 19 Aug 2013. Due to the significant deterioration of the epidemiological situation regarding the incidence of tularemia in Khanty-Mansiysk, an emergency situation has been declared. (Tularemia is listed in Category A on the CDC List of Critical Biological Agents) *Non-suspect case

PARALYTIC SHELLFISH POISONING (AUSTRALIA): 18 September 2013, High levels of potentially toxic microscopic algae have been recorded in shellfish in South Yunderup [Western Australia] in recent testing. The Shire of Murray is urging residents and visitors to avoid eating all wild shellfish from the Peel-Harvey Estuary. Filter feeding shellfish absorb the algae, which are capable of producing toxins. Cooking cannot destroy the toxins and the shellfish could cause poisoning if consumed. Symptoms of shellfish poisoning include nausea, cramping, vomiting, and diarrhea. "The Shire continues to work closely with the Department of Water and Health to monitor algae levels in the estuary," chief executive Dean Unsworth said. Anyone who has consumed shellfish from these waters and experiences poisoning symptoms should seek medical attention. Wild shellfish from inland water sources should not be eaten, as water quality and safe consumption cannot be guaranteed. These species include oysters, mussels, clams, pipis, scallops, cockles, and razor clams. Shellfish purchased in supermarkets are not affected as these products must adhere to food quality assurance programs to ensure they are safe for consumption. For more information contact the Shire of Murray on 9531 7777 or visit the Department of Health website for further details regarding wild shellfish collection. (Food Safety Threats are listed in Category B on the CDC List of Critical Biological Agents) *Non-suspect case

MERS-COV (SAUDI ARABIA): 18 September 2013, Within the framework of the constant monitoring and epidemic surveillance of the novel Coronavirus (MERS-CoV), the Ministry of Health (MOH) has announced that 3 new cases have been recorded. The 1st case is a 75-year-old female citizen in Madinah, who was in contact with a confirmed case of this virus, and she had been suffering some chronic diseases. She passed away. The 2nd case is a 35-year-old male citizen in Madinah, who was in contact with a confirmed case of this virus, and he has been suffering some chronic diseases. He is currently in the ICU, receiving the proper treatment. The 3rd case is a 83-year-old male citizen of Riyadh, who had been suffering some chronic diseases. He passed away. (Emerging infectious diseases are listed in Category C on the CDC List of Critical Biological Agents) *Non-suspect case

FOODBORNE ILLNESS (GHANA): 16 September 2013, Jacobu, the capital of Amansie Central District in the Ashanti Region, was hit by a food poisoning scare at the weekend [14-15 Sep 2013] when scores of people, including journalists, chiefs, and policemen, were taken ill after eating at a reception held at the end of a program organized by the district assembly to endorse the new District Chief Executive (DCE). Eyewitnesses said there was a lot to eat at the reception, with some of the guests carrying excess food in packs to their homes. In a chain reaction, they suffered symptoms such as vomiting and diarrhea and were rushed to various health facilities for treatment in Kumasi, Bekwai, and Obuasi. Among those from Kumasi were reporters with some radio stations. One of them gave some of the food to the wife to eat and minutes later, she started vomiting and defecating and the 2 were taken to hospital. No deaths have occurred but a distraught DCE, Mr Emmanuel Dede-Appiah, told the Daily Graphic last Saturday night, 14 Sep 2013, that at least 60 people were taken to the district hospital and a private clinic at Jacobu. "It's terrible. Even the chief of my town is a victim but I thank God that no one has lost his or her life," the DCE said. A source at the Jacobu Police also said 7 policemen who took the meal also fell ill and were rushed to the local hospital for treatment. It said the police were investigating the incident. A health official at the Jacobu hospital, confirming the situation in a telephone interview with the Daily Graphic, said medical officers worked hard on the victims to save lives. Health authorities at Jacobu were testing samples of the food eaten and the stool of victims to detect what caused the near calamity. But the DCE said the victims appeared to have eaten jollof with shito [see details below]. According to Mr Dede-Appiah, those who ate other dishes including tuo-zaafi, fufu, and banku did not complain of any complications. The DCE said the food served at the reception was from 3 sources. Some of it was prepared by his wife, with the rest coming from the district assembly and a private caterer at Obuasi. "But for now, I don't know where the jollof and shito came from, " he added. (Food Safety Threats are listed in Category B on the CDC List of Critical Biological Agents) *Non-suspect case

*National and International Disease Reports are retrieved from http://www.promedmail.org/.

OTHER RESOURCES AND ARTICLES OF INTEREST

More information concerning Public Health and Emergency Preparedness can be found at the Office of Preparedness and Response website: http://preparedness.dhmh.maryland.gov/

Maryland's Resident Influenza Tracking System: http://dhmh.maryland.gov/flusurvey

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NOTE: This weekly review is a compilation of data from various surveillance systems, interpreted with a focus on a potential BT event. It is not meant to be inclusive of all epidemiology data available, nor is it meant to imply that every activity reported is a definitive BT event. International reports of outbreaks due to organisms on the CDC Critical Biological Agent list will also be reported. While not "secure", please handle this information in a professional manner. Please feel free to distribute within your organization, as you feel appropriate, to other professional staff involved in emergency preparedness and infection control.

For questions about the content of this review or if you have received this and do not wish to receive these weekly notices, please e-mail us. If you have information that is pertinent to this notification process, please send it to us to be included in the routine report.

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Syndrome Definitions for Diseases Associated with Critical Bioterrorism-associated Agents

Table: Text-based Syndrome Case Definitions and Associated Category A Conditions

Syndrome	Definition	Category A Condition
Botulism-like	ACUTE condition that may represent exposure to botulinum toxin ACUTE paralytic conditions consistent with botulism: cranial nerve VI (lateral rectus) palsy, ptosis, dilated pupils, decreased gag reflex, media rectus palsy. ACUTE descending motor paralysis (including muscles of respiration) ACUTE symptoms consistent with botulism: diplopia, dry mouth, dysphagia, difficulty focusing to a near point.	Botulism
Hemorrhagic Illness	SPECIFIC diagnosis of any virus that causes viral hemorrhagic fever (VHF): yellow fever, dengue, Rift Valley fever, Crimean-Congo HF, Kyasanur Forest disease, Omsk HF, Hantaan, Junin, Machupo, Lassa, Marburg, Ebola ACUTE condition with multiple organ involvement that may be consistent with exposure to any virus that causes VHF ACUTE blood abnormalities consistent with VHF: leukopenia, neutropenia, thrombocytopenia, decreased clotting factors, albuminuria	VHF
Lymphadenitis	ACUTE regional lymph node swelling and/ or infection (painful bubo- particularly in groin, axilla or neck)	Plague (Bubonic)
Localized Cutaneous Lesion	SPECIFIC diagnosis of localized cutaneous lesion/ ulcer consistent with cutaneous anthrax or tularemia ACUTE localized edema and/ or cutaneous lesion/ vesicle, ulcer, eschar that may be consistent with cutaneous anthrax or tularemia INCLUDES insect bites EXCLUDES any lesion disseminated over the body or generalized rash EXCLUDES diabetic ulcer and ulcer associated with peripheral vascular disease	Anthrax (cutaneous) Tularemia
Gastrointestinal	ACUTE infection of the upper and/ or lower gastrointestinal (GI) tract SPECIFIC diagnosis of acute GI distress such as Salmonella gastroenteritis ACUTE non-specific symptoms of GI distress such as nausea, vomiting, or diarrhea EXCLUDES any chronic conditions such as inflammatory bowel syndrome	Anthrax (gastrointestinal)

Syndrome Definitions for Diseases Associated with Critical Bioterrorism-associated Agents
(continued from previous page)

Syndrome	Definition	Category A Condition
Respiratory	ACUTE infection of the upper and/ or lower respiratory tract (from the oropharynx to the lungs, includes otitis media) SPECIFIC diagnosis of acute respiratory tract infection (RTI) such as pneumonia due to parainfluenza virus ACUTE non-specific diagnosis of RTI such as sinusitis, pharyngitis, laryngitis ACUTE non-specific symptoms of RTI such as cough, stridor, shortness of breath, throat pain EXCLUDES chronic conditions such as chronic bronchitis, asthma without acute exacerbation, chronic sinusitis, allergic conditions (Note: INCLUDE *acute exacerbation* of chronic illnesses.)	Anthrax (inhalational) Tularemia Plague (pneumonic)
Neurological	ACUTE neurological infection of the central nervous system (CNS) SPECIFIC diagnosis of acute CNS infection such as pneumoccocal meningitis, viral encephailitis ACUTE non-specific diagnosis of CNS infection such as meningitis not otherwise specified (NOS), encephailitis NOS, encephalopathy NOS ACUTE non-specific symptoms of CNS infection such as meningismus, delerium EXCLUDES any chronic, hereditary or degenerative conditions of the CNS such as obstructive hydrocephalus, Parkinson's, Alzheimer's	Not applicable
Rash	ACUTE condition that may present as consistent with smallpox (macules, papules, vesicles predominantly of face/arms/legs) SPECIFIC diagnosis of acute rash such as chicken pox in person > XX years of age (base age cut-off on data interpretation) or smallpox ACUTE non-specific diagnosis of rash compatible with infectious disease, such as viral exanthem EXCLUDES allergic or inflammatory skin conditions such as contact or seborrheaic dermatitis, rosacea EXCLUDES rash NOS, rash due to poison ivy, sunburn, and eczema	Smallpox
Specific Infection	ACUTE infection of known cause not covered in other syndrome groups, usually has more generalized symptoms (i.e., not just respiratory or gastrointestinal) INCLUDES septicemia from known bacteria INCLUDES other febrile illnesses such as scarlet fever	Not applicable

Syndrome Definitions for Diseases Associated with Critical Bioterrorism-associated Agents (continued from previous page)

Syndrome	Definition	Category A Condition
Fever	ACUTE potentially febrile illness of origin not specified INCLUDES fever and septicemia not otherwise specified INCLUDES unspecified viral illness even though unknown if fever is present EXCLUDE entry in this syndrome category if more specific diagnostic code is present allowing same patient visit to be categorized as respiratory, neurological or gastrointestinal illness syndrome	Not applicable
Severe Illness or Death potentially due to infectious disease	ACUTE onset of shock or coma from potentially infectious causes EXCLUDES shock from trauma INCLUDES SUDDEN death, death in emergency room, intrauterine deaths, fetal death, spontaneous abortion, and still births EXCLUDES induced fetal abortions, deaths of unknown cause, and unattended deaths	Not applicable